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[Reprint from *The Laryngoscope*, St. Louis, April, 1897.]

EXOSTOSIS OF THE SEPTUM AS A CAUSE OF CHRONIC NASO-PHARYNGITIS.*

BY CHARLES H. KNIGHT, M.D., NEW YORK.

One of the most obstinate and annoying disorders met with in the upper air tract is chronic naso-pharyngitis. Its prominent subjective symptoms are a sensation as of a foreign body above the soft palate and a frequent desire to clear the throat by the act of "hawking." The subjects of this condition are prone to attacks of acute naso-pharyngitis, which may be very rebellious to treatment. They often form a peculiar habit of forcibly expelling short blasts of air through the nostrils in an instinctive effort to get rid of an obstruction. This little trick, repeated at intervals of a few minutes, becomes a source of great annoyance to the patient's associates. In an ordinary "cold in the head," which everyone has at times and almost everybody neglects as being a trivial affair, the naso-pharynx usually becomes involved earlier or later. As a matter of clinical experience, we find that attacks of acute naso-pharyngitis are exacerbations of a chronic condition, and are encouraged by the existence of some nasal abnormality, such as a septal deflection, or an hypertrophy of the posterior end of the inferior turbinated body. The relation of naso-pharyngitis to lymphoid hypertrophy in the vault of the pharynx, to inflammation of the pharyngeal bursa, and to suppuration in the accessory sinuses, is by no means infrequent, and many cases, on careful examination, will prove to have their source in one or the other of these pathological conditions.

What is believed to be a very common etiological factor in post-nasal disorders, and one easily overlooked in the usual rhinoscopic examination, is *exostosis of the septum.* It has been my frequent experience to meet with cases of obstinate "post-nasal catarrh," so-called, associated with a tendency to "catch cold," which yielded only after the removal of a conical projection from the bony septum, so situated as to interfere with breathing or drainage. Such a projection may assume the form of an irregular ridge running forward more or less parallel with the floor of the nose, and impinging upon or even adhering to the inferior or middle turbinated body. Under such

*Read before the Section in Laryngology of the New York Academy of Medicine, December 23, 1896.

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circumstances, it can hardly escape detection. It may be concealed by an anterior turbinated hypertrophy, or a deviation of the septum, and may be discovered only by the use of cocaine and the probe. No rhinoscopic examination is complete without recourse to these aids to diagnosis.

It is uncertain whether these exostoses of the septum originate in traumatism or result from hypernutrition. They are seldom, if ever, met with in early life, which hardly would be the case if the former were the sole cause. Moreover, they are found far back upon the vomer in a situation supposed to be especially protected from injury. Behind such an obstruction there always exists a more or less extensive area of hyperemia owing to rarefaction of the air during inspiration. This region is, therefore, more susceptible to the influences which are usually recognized as conducive to an acute naso-pharyngitis. The disturbances due to diminution in air pressure are perhaps less serious than those dependent upon impeded nasal drainage. In other words, a very considerable bony obstruction may exist without marked derangement of the nasal respiratory function. Either its growth is so slow that the patient becomes habituated to it, or else the opposite nostril is so ample as to compensate for the stenosis, or possibly it may be quite above the level of the air current. Such a projecting shoulder offers a site for the lodgment and retention of secretion, which in process of decomposition becomes an additional source of irritation. The indications are therefore clear in every case of chronic naso-pharyngitis—in the first place, to supplement simple inspection of the nasal chambers by exploration with the probe after thorough cocainization, and, secondly, to remove all overgrowths from the septal surface which seem to obstruct respiration or drainage. The latter statement may seem somewhat radical, but I believe it may be accepted even by those conservatives who deprecate the unwarrantable activity in nasal surgery which has prevailed in recent years.

Whatever good may be accomplished in certain cases of catarrhal disease by the list of astringents and various local applications usually recommended, they will fail to give permanent relief when the mechanical obstruction referred to exists as an etiological factor. In every case of intractable and recurrent naso-pharyngitis, it should be sought for, and, if present, removed.

I hope that my position on the question of intranasal surgery may not be misunderstood. It is very far from my intention to urge the removal of every septal irregularity. On the contrary, I believe it is high time that we should learn to have more respect for the intranasal structures. No one condemns more heartily than myself the

wholesale slaughter of turbinates which may seem to be simply a little larger than our æsthetic taste demands. But, on the other hand, there can be no good reason in attempts at preserving a membrane which has undergone polypoid degeneration, or in a state of such advanced hyperplasia that its function is wholly abrogated. The late Dr. Henry Schweig, of this city, many years ago advocated the plan of "submucous cauterization" of the hypertrophied turbinates, and for the purpose used a sharp-pointed cautery electrode. The idea has been lately revived by Blondian*, and in another form by Dr. Norval H. Pierce†, of Chicago. Efforts in this line are certainly most commendable, provided they be limited to tissues which are still useful. There certainly can be no sense in trying to save those which are practically foreign bodies. The advice is sometimes given to trim down the turbinated bodies rather than meddle with a deformed septum in cases of nasal stenosis, the impression being that the septum is particularly resentful of surgical interference. In cases of the class referred to in my paper, I believe there should be no hesitation in choosing to attack the septum. In my experience these wounds do well. Examined months and years after operation, no trace of the original trouble can be seen except perhaps a slight bulging of the septal surface. Hemorrhage at the time of operation, or after the cocaine effects have passed away, is often quite free, but only on two or three occasions have I found it necessary to plug the nostril. Under the use of a fresh, strong solution of cocaine the removal of an exostosis may be accomplished absolutely without pain, unless the patient is the unfortunate victim of an idiosyncrasy which resists the anesthetic effects of the drug. Some of our patients seem to enjoy the distinction associated with a surgical operation, while others dread the knife and will submit to months of treatment with sprays and medication rather than take the chance of pain. It is a satisfaction to be able to assure such individuals that no great amount of pain need be apprehended either during the operation or afterwards. The increase in comfort as regards nasal breathing, and the relief from symptoms following the removal of one of these septal deformities, are generally admitted to be full compensation.

In conclusion, let me say a few words regarding the method of removing an exostosis. When its projection from the surface of the septum is abrupt, there is but little difficulty in operating with a hand saw. And in most cases a saw, preferably one of the pattern known as Bosworth's, is a convenient instrument. If the base of the bony spur is

*The *Jour. Laryngology*, etc., Dec. 1886, p. 333.

†The *N. Y. Med. Jour.*, 1896, No. 938.

shelving, the saw should be started in an oblique position, its teeth being directed towards the septal surface. When once it has made a furrow through the soft parts, it may be brought to a vertical line without danger of slipping. In order to obviate stripping up the mucous membrane at the completion of the section, it is a good plan to make a preliminary cut from below upwards, the main division of the bone being made from above downwards. The various electric saws, devised or modified by Roe, Schmidt, Potter, Black, and others, are very ingenious, and are thought to have the advantage of doing the work more quickly. In exostosis of unusual width, it will be found easier to tunnel through with the electric nasal trephine, and afterwards trim off the projections left by the trephine with cutting forceps or the saw. Exostoses of moderate extent, which have not become densely ossified, may be removed with the spokeshave, suggested by Woakes; but I am almost prepared to say that a septal excresence which this instrument is capable of removing, does not require interference. Bony outgrowths often offer too great resistance; soft hyperplasiæ are better reduced by means of the electric cautery.

Nothing has been said about the relation of septal exostosis to reflex neuroses, or to various aural disturbances—not because it is by any means infrequent or unimportant; but because this phase of the subject opens too wide a field for discussion at the present time.

To most of you I fear that the contents of my paper may seem extremely elementary. But I cannot help feeling that in our search for strange and unusual morbid phenomena, we are apt to forget first principles. An occasional review of the field and a comparison of experiences may be of value to all of us.